

MONTANA DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

Quality Assurance Division-Licensure Bureau

2401 Colonial Drive

P.O. Box 202953

Helena, MT 59620-2953

FAX: (406) 444-1742

**APPLICATION FOR MONTANA STATE RESIDENTIAL CARE FACILITY LICENSE
ASSISTED LIVING FACILITY APPLICATION**

Initial Application ☐

Renewal Application ☐

☐ **Category A**

☐ **Category B (5 or less)**

☐ **Category C**

(Include Completed Category B and C applications if applying for these licenses)

Total Number of Beds _____

Facility Name: _____

Facility Address: _____ PO Box _____

City: _____ State/Zip: _____

County: _____

Facility Telephone Number: _____ FAX: _____

Facility E-mail/Web page Address: _____

Name of Applicant: _____

Applicant Address: _____ City: _____ State/Zip: _____

Applicant (or contact) e-mail address: _____

Name of Administrator: _____

Administrator Address: _____ City: _____ State/Zip: _____

Administrator e-mail: _____

- **37.106.2814 ADMINISTRATOR (2)** (a) the administrator must hold a current Montana nursing home administrator license;
or
(b) have proof of holding a current and valid nursing home administrator license from another state; or
(c) have successfully completed all of the self study modules of "The Management Library for Administrators and Executive Directors", a component of the assisted living training system published by the assisted living federation of America university (ALFA); or
(i) be enrolled in the self study course referenced above, with a six month successful completion;

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Owner (If different from Applicant): _____

Owner Address: _____ City: _____ State/Zip: _____

Name and Address of Management Company if different from owner:

Floor Plan is: ☐ New Construction ☐ Existing Structure ☐ Addition ☐ Remodeled

Information on ownership, contract or lease agreement if operated by a person other than the owner:

- ☐ If a partnership, firm or association, list every member thereof.
- ☐ If a corporation, list the name and address thereof and the names of its officers.
- ☐ State Affiliated Organization

NAME

ADDRESS

(Please attach additional sheets as needed.)

I certify that all information I have submitted to DPHHS is true and correct. This Application for license for an Assisted Living Facility is hereby submitted under the provision of Section 50-5-101 through 50-5-208 and 50-5-225 through 50-5-226.

SIGNED _____ **DATE** _____

TITLE _____

ADDRESS: _____ **CITY** _____ **STATE/ZIP** _____

Enclose a check, money order or draft made payable to the *Department of Public Health & Human Services* to cover the license fee. The fee is determined as follows:

(a) facilities with 20 or less = \$20.00

(b) facilities with 21 beds or more = \$1.00 per bed.

This fee will be deposited in the State Treasury and is non-refundable.